Managed Care Plan Utilization Data: Beginning 2009

OVERVIEW

Office of Quality and Patient Safety
December 2018

Health Data NY

NEW YORK STATE | Department of Health | All Payer Database

General Description:

Public Health Law (Article 29-D Section 2995) stipulates the collection of health care data for the purposes of increasing the information available to patients about health care providers and health care plans, and improving the quality of health care in this state, by creating a statewide health information system, collecting health information for dissemination by means of such system, and studying additional uses of such information. The New York State Department of Health (NYSDOH) collects the data on children's and adults' use of health services. This information complements the quality of care and member satisfaction information collected through an annual public reporting system called the Quality Assurance Reporting Requirements (QARR). Managed care organizations (licensed pursuant to Article 44) and preferred provider organizations (licensed pursuant to Article 32, 43 or 47) must report all applicable utilization data annually.

The data collected is largely based on measures of utilization established by the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS®). Utilization measures are designed to capture the frequency of certain services provided by a health plan in the areas of outpatient, inpatient, mental health, alcohol and other drug, selected procedures, and antibiotic prescriptions.

Data Methodology:

Data in this report are collected from Commercial HMOs, PPOs, Medicaid, and Child Health Plus managed care plans in compliance with HEDIS® Volume 2 specifications. For more information on the technical specifications for HEDIS® see NCQA website (www.ncqa.org). Prior to submission of their data to the New York State Department of Health, all plans are required to participate in an audit of all required measures. The audit is conducted by an independent auditor in adherence to NCQA's certified audit methodology.

Statistical and analytical issues:

Results for measures are calculated differently based on the type of service. For outpatient services and frequency of selected procedures, results are calculated as rate per 1,000 member years. For mental health service as well as identification of alcohol and other drug service, results are calculated as percentage of members receiving the service. For inpatient services, discharge and total days are presented as rate per 1,000 member years; average length of stay is calculated as total days divided by total discharges. For antibiotic services, average number of prescription for antibiotics and for antibiotics of concern are presented as per 1,000 member years; percentage of prescriptions for antibiotics of concern of all antibiotic prescriptions is calculated as total number of prescription for antibiotics of concern in the year divided by total number of antibiotic prescription in the year.

Level of significance is used to indicate those plans with results at the 90th percentile or above and at the10th percentile or below among all health plans.

Limitations of Data Use:

Utilization measures are designed to capture the frequency of certain services provided by health plans. NCQA does not view higher or lower services counts as better or worse performance.

For mental health utilization as well as identification of alcohol and other drug service, results are calculated as percentage of members receiving the service. Member months are used to estimate the total eligible members in order to obtain percentage of members receiving the service.

Plans with fewer than 30 eligible events are excluded from the statistical calculations of the percentiles, but are still included in the calculation of the statewide averages. All rates based on events of less than 30 are suppressed and the level of significance will be labeled as small sample size.